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BEFORE THE
DENTAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **TRUPTI PARTHIV DESAI** **24539 Los Alisos Blvd, Apt. #321** **Laguna Hills, CA 92653** **P.O. Box 2544** **Ruwi - Masqat** **Oman 112** **Dental License No. 47876** Respondent.	Case No. **DBC 2010-115** **A C C U S A T I O N**

Complainant alleges:

PARTIES

1. Richard DeCuir (Complainant) brings this Accusation solely in his official capacity as the Executive Officer of the Dental Board of California, Department of Consumer Affairs.

2. On or about December 19, 2000, the Dental Board of California issued Dental License No. 47876 to Trupti Parthiv Desai (Respondent). The Dental License was in full force and effect at all times relevant to the charges brought herein and will expire on April 30, 2013, unless renewed.

JURISDICTION

3. This Accusation is brought before the Dental Board of California (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 1670 states, in pertinent part:

Any licentiate may have his license revoked or suspended or be reprimanded or be placed on probation by the board for unprofessional conduct, or incompetence, or gross negligence, or repeated acts of negligence in his or her profession, or for the issuance of a license by mistake, or for any other cause applicable to the licentiate provided in this chapter. The proceedings under this article shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, and the board shall have all the powers granted therein.

5. Section 1680 states, in pertinent part:

Unprofessional conduct by a person licensed under this chapter is defined as, but is not limited to, any one of the following:

. . . .

(n) The violation of any of the provisions of this division.

. . . .

(u) The abandonment of the patient by the licensee, without written notice to the patient that treatment is to be discontinued and before the patient has ample opportunity to secure the services of another dentist, registered dental hygienist, registered dental hygienist in alternative practice, or registered dental hygienist in extended functions and provided the health of the patient is not jeopardized.

. . . .

(x) Any action or conduct which would have warranted the denial of the license.

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6. Section 1683 states, in pertinent part, that every dentist who performs a service on a patient in a dental office shall identify herself in the patient record by signing her name or an identification number and initials, next to the service performed and shall date those treatment entries in the record. Repeated violations of this section constitute unprofessional conduct.

7. Section 1685 states, in pertinent part:

In addition to other acts constituting unprofessional conduct under this chapter, it is unprofessional conduct for a person licensed under this chapter to... knowingly permit the delivery of dental care that discourages necessary treatment or permits clearly excessive treatment, incompetent treatment, grossly negligent treatment, repeated negligent acts, or unnecessary treatment, as determined by the stated of practice in the community.

8. Section 118, subdivision (b), of the Code provides that the expiration, surrender, or cancellation of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued or reinstated.

9. Section 1718 of the Code provides, in pertinent that an expired dental license may be renewed within five years after its expiration by filling out a renewal form and paying all accrued renewal and delinquency fees.

COST RECOVERY

10. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

FACTS

Patient P.M.

11. On or about January 14, 2009, the Board received a Consumer Complaint Form from patient P.M. with respect to treatment she received from July 2007 through August 2008 from Respondent.

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12. The complaint included correspondence from Patient P.M. to Respondent, reiterating the following, in pertinent part:

Tooth #20 and #21

a. In April 2008, Respondent performed a procedure on Patient P.M. on tooth #20 and #21. Tooth #21 needed a root canal with post, decay removal, and a new crown. Tooth #20 needed a new crown.

b. In October 2008, the crown fell off of tooth #21, and Patient P.M. returned to Respondent's office to have the crown re-cemented. Patient P.M. was informed that Respondent was no longer working for that dental office.

c. Patient P.M. was instructed by the owner of the dental office to see a periodontal specialist to determine whether he could perform a crown-lengthening procedure, as part of the fractured tooth structure was inside the dislodged crown, and there was not enough tooth structure left to hold the crown. The specialist advised against crown lengthening, and stated that the only way to correct this condition is an extraction and replacement with an implant. He also noted that the post was inserted off center.

Tooth #8, #9, and #10

d. Respondent advised Patient P.M. that she needed a new bridge on teeth #8, #9 and #10 (upper front) because the previous bridge was cracked. This procedure was completed in August 2007. Teeth #9 and #10 began to protrude outward, giving the appearance of "buck teeth" and making Patient P.M. extremely self-conscious because it is "very unattractive."

e. In August 2008, Patient P.M. advised Respondent of this problem, and Respondent stated that Patient P.M. needed a night guard, which Patient P.M. ordered, and Respondent attempted to file the bridge.

f. When Patient P.M. returned in October 2008 and was informed that Respondent was no longer employed at the dental office, the other dentist at the office examined Patient P.M. and refused to redo any procedures that Respondent was "responsible for."

g. Patient P.M. consulted with an orthodontic specialist to determine if braces or a retainer would straighten the front bridge. She was advised against any orthodontic treatment.

h. Patient P.M. discovered that the lab that created the crown offered a two year guarantee on all crowns.

i. Patient P.M. advised that she was under a great deal of discomfort and distress. She asked Respondent to correct the procedures she had previously performed.

13. On or about March 30, 2009, Respondent submitted a letter to the Board stating that Patient P.M. had provided Respondent with a letter documenting that Patient P.M. "has nothing against" Respondent. Respondent stated that she had "made favorable arrangements to help" Patient P.M. with the issues she had complained about.

14. The letter from Patient P.M., which was addressed to the Board, stated that she had been in touch with Respondent regarding the complaint that Patient P.M. filed with the Board. The letter states that Respondent was definitely an employee of the dental office, and that the dental office was paid for all dental work. Patient P.M. stated that the dental office carries insurance, and that the other dentist in the office "abandoned" her, and refused to put in a claim with the lab which was willing to redo all of the work.

15. On or about April 6, 2009, at the request of Patient P.M., the complaint against Respondent was closed.

16. On or about July 27, 2009, Patient P.M. submitted additional information to the Board requesting that her complaint against Respondent be reopened because Respondent abandoned her in the middle of replacing her front three teeth bridge.

17. Patient P.M. stated that Respondent made arrangements to remove the old bridge (gold filled) and order a new bridge from the original lab. When Patient P.M. picked up the new bridge, it was metal, not gold, and not captex. Patient P.M. stated that the bridge looked like "beaver teeth." Patient P.M. immediately returned to the lab and asked why the bridge was not filled with gold as was the previous bridge. The lab advised Patient P.M. that the old bridge was never returned. Patient P.M. stated that the old bridge contained gold and was valued at over $800.00. Patient P.M. suspected that it had been sold for the gold value. Patient P.M. further stated that Respondent never contacted the lab to discuss the problems with the previous bridge.

Patient P.M. was forced to wear an off-color temporary bridge for months, and was forced to have the work re-done by another dentist.

18. Patient P.M. provided the Board with a letter from her subsequent treating dentist, dated February 16, 2009, which stated the following:

a. Patient P.M. came to their office on February 2, 2009 and complained of #8-#10 bridge being tilted facially since its initial cementation in August 2007. Upon examination, they noticed a lack of parallelism between the abutment crown #8 and the remainder of the bridge (#9 and #10). At the connection between #8 and #9 the porcelain covering the metal frame had been fractured, which suggests a distortion following the initial placement of the bridge.

b. The abutment crown #10 is displaced facially from its abutment tooth.

c. The metal frame of the bridge, a gold alloy by its color, is two millimeters wide and of undetermined thinness at the junction between #8 and #9. The lack of strength of this frame combined with imbalanced occlusion could explain the bend of the bridge. The subsequent treating dentist stated that in his evaluation, the bridge should be redone.

d. The crown on tooth #21 could be removed with the fingers. The buildup material was attached to the crown while the retaining post stood with the root. The post could not retain the buildup due to its smooth, thin, cylindrical shape and due to a lack of additional retention. The root surface was flat, unable to offer the necessary additional retention or resistance to the crown's turn around the smooth, cylindrical post. The post on tooth #21 is too short, off-center, close to perforating the mesial aspect of the root, 3 mm from the cavo-surface and 0.7 mm from the periodontal ligament. The subsequent treating dentist recommended that tooth #21 be extracted and replaced with an implant.

19. Respondent subsequently lost tooth #21, and was then missing three teeth.

20. On or about July 31, 2009, the Board's case against Respondent was re-opened.

Summary of Dental Procedures

Respondent

21. Radiographs from Respondent's dental office dated 12/21/2005 are present but there are no progress notes present in Patient P.M.'s file.

22. Radiographs from Respondent's dental office dated 2/26/2007 are present, but there are no progress notes present in Patient P.M.'s file.

23. On April 9, 2007, preps of #20 and #21 were done by Respondent. Two carps of 2% Lidocaine were used. Temporaries were placed, but there is no note of material type or cement type.

24. On April 26, 2007, crowns #20 and #21 were cemented with Ketac by Respondent. There is no signature. There are two bitewing radiographs present from this date but they are not mentioned in the treatment notes.

25. On July 21, 2007, preps #8-#10 done with 2 carps 2% Lidocaine. Temporary is cemented with no mention of materials. This note appears to be on a plain piece of paper, not on progress notes.

26. On August 8, 2007, bridge #8-#10 was cemented. No note of cement type.

27. On October 16, 2007, Patient had an appointment for a tooth ache for #21. Patient was given a prescription for Vicodin ES #28 every six hours as needed for pain, and another appointment was scheduled. There is no name given for who treated Patient P.M. on that date.

28. On a date uncertain in August 2008, an impression was taken for a night guard.

Dr. Chen

29. On October 18 and 24, 2008, Patient P.M. was seen by Dr. Chen for #21. One radiograph is taken on October 18, 2008 of #21. This shows a completed root canal on #21 that was not mentioned in any of the previous progress notes. It is advised that #21 be extracted and a dental implant be placed. Dr. Chen's treatment notes state that #21 endo and crown done in February 2008, per patient history. Recurrent decay is noted on this tooth.

Dr. Shawn Yu

30. On November 8, 2008, Patient P.M. consulted with orthodontist Shawn Yu because of the alignment of bridge #8-#10. Orthodontics are not recommended. Restorative replacement is recommended by Dr. Yu.

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Dr. Michael Hansen

31. On February 2, 2009, Patient P.M. saw Dr. Michael Hansen. His report states that the bridge #8-#10 has fractured porcelain. This bridge appears to have some gold alloy. He recommends a new bridge due to poor bridge design and aesthetics. The build-up had separated from the post and he noted that the post is short, off-center, and close to perforating the mesial of #21. He also recommended an implant for #21. His clinical notes stated that an FMX was taken on February 2, 2009. These films were not included with the record as it stated that Patient P.M. took both the original films and the copies of the films.

32. On February 10, 2009, #21 was temporarily cemented by Dr. Hansen.

33. On February 17, 2009, #21 was temporarily cemented by Dr. Hansen.

Respondent

34. From March 28-June 15, 2009, it appears that Respondent removed the old bridge and placed a temporary bridge. The final bridge was never cemented due to apparent dissatisfaction with the aesthetics and material of the bridge.

Dr. Michael Hansen

35. On May 16, 2009, the temporary bridge #8-#10 is recemented by Dr. Hansen.

36. On June 13, 2009, the temporary bridge #8-#10 is recemented by Dr. Hansen.

37. On August 10, 2009, the #20 crown is recemented by Dr. Hansen. The notes say that prep is short and convergent.

Findings

38. There are repeated departures of the standard of care in crown (crown preparation of #20 and #21 is inadequate, with over prepped and convergent walls, with recurrent decay noted on #21) and bridge (bridge preparation of #8-#10 and/or lab work is deficient) and endodontics (poor fill in tooth #21 and a too-short post that is off-center, causing fracture of the tooth and almost perforates the tooth).

39. Early endodontic referral may have prevented the fracture of #21. A final bridge that meets the patient's expectations should have been permanently cemented for #8-#10.

40. There is extremely poor record keeping. There are many entries with no signatures. For endodontic therapy on tooth #21, there is no clinical entry, no note of anesthetic, rubber dam use, medicaments used for irrigation, file working length film, note of working length or temporary or permanent restorative material.

41. The preparation of design of tooth #8-#10 is in question because the porcelain fractured early in its use. The conical and short preparation of tooth #20 was noted by another dentist when the crown had to be recemented.

42. Respondent left the country and allowed her license to go inactive while Patient P.M. was in a temporary bridge.

Patient C.E.

43. On or about August 23, 2010, the Board received a Consumer Complaint Form from Patient C.E. with respect to treatment she received from August through September, 2007, from Respondent.

44. The complaint alleged, in pertinent part, that on Patient C.E.'s last visit to Respondent's dental office on or around September 23, 2007, Patient C.E. forgot to remind them that she suffers from hypertension, even though it is listed in her chart. Patient C.E. stated that she was injected with something that had an adverse effect. Patient C.E. stated that "some time passed," and Respondent began working on her for what "seemed like forever." Respondent "muttered something," and Patient C.E. "jumped out of the chair." Patient C.E. stated that she was so traumatized that she never returned to Respondent's office. Patient C.E. stated that she then sought subsequent care from a different dental office because she was in pain, at which time the diseased molar was extracted. Patient C.E. stated that she had to pay to replace some of the teeth she lost due to the negligence of Respondent, and has three molars which can only be replaced by dental implants.

45. Patient C.E.'s subsequent treating dentist, Dr. Forouzan Yavari, submitted correspondence stating that Patient C.E. presented to his office on March 10, 2009 with pain on the lower right side. Patient C.E. informed Dr. Yavari that she had a bridge in the area that was done one year prior to her visit with him. Dr. Yavari stated that the patient told him she had seen

another dentist two months prior to being seen by Dr. Yavari regarding this bridge, and that dentist advised her that she required a root canal on tooth #31.

46. Dr. Yavari's correspondence also stated that his office took two periapical x-rays and a bitewing of the area on March 10, 2009. Patient C.E. is missing tooth #30, and there was a bridge present from tooth #29-#31.

47. Dr. Yavari's correspondence further stated that, upon visual, radiographic, and periodontal examination, his findings were that Patient C.E. had a large swelling (infection) in the buccal gingival and evidence of caries under the crown on tooth #31 that appeared radiographically to have furcation involvement. The probing depths of this area confirmed that there were 7-8mm pockets with furcation involvement, and there was moderate bone loss present. Dr. Yavari stated that he advised Patient C.E. that the bridge should be removed and tooth #31 should be evaluated for its potential restorability.

48. Dr. Yavari's correspondence stated that Patient C.E. returned to his office the following day, March 11, 2009, at which time he cut the abutment from tooth #30 and #31. The removed the restoration from tooth #31 and found that cotton and cavit along with gross deep caries were present. They removed the cavit, cotton pellet that had been left in the tooth, and took intraoral photographs. It appeared that the tooth had had an "open and med" procedure performed on it at some time; however, root canal therapy was never performed. Due to the deep caries underneath the crown, extensive and to the area of the pulpal floor with furcation involvement through and through, the tooth was deemed non-restorable. There was insufficient structure remaining to salvage the tooth. The tooth was surgically extracted the same day in Dr. Yavari's office.

Summary of Dental Procedures

Respondent

49. On August 6, 2007, bridge prep tooth #29-#31 with 3 carpules 3% Carbocaine. There is a note that there is deep decay on tooth #31, and that endodontic therapy may be needed. Impressions taken for bleaching trays.

50. Date unknown- delivered the bleaching trays.

51. On ?/?/2007 (date unclear), tooth #29-#31 bridge cemented. There is no note of the type of cement used.

52. On ?/?/2008 (date unclear), Patient C.E. called to TA lower right quadrant. Patient was given a prescription for Amoxicillin and Vicodin.

53. On or about May 2, 2008, Patient C.E. came in for an office visit for TA on tooth #31, and was referred to an endodontist for treatment.

Dr. Forouzan Yavari

54. On March 10, 2009, Patient C.E. was seen with tooth #31 swelling and 7-8 mm periodontal pockets with furcation involvement. Patient advised that tooth #31 crown needs to be removed for diagnosis.

55. On March 11, 2009, tooth #31 crown was removed and the cotton and temporary material is discovered. Intraoral photos are taken to document this condition. Tooth #31 is not restorable, and is extracted.

56. On March 18, 2009, PO check for tooth extraction #31. Patient C.E. is healing well.

Findings

57. There was incomplete caries removal of tooth #31 when the tooth was prepped from the bridge in August 2007. There appears to be an incomplete endodontic procedure done on tooth #31, and there are no clinical notes about this procedure. Cotton and temporary material was found under the permanently cemented bridge. This condition was documented in 2009 by a subsequent treating dentist. The failure to properly treat tooth #31 lead to the loss of tooth #31. Since tooth #31 is a bridge abutment, tooth #30 would also be lost.

58. Cotton and temporary material was found under the permanently cemented bridge for teeth #29-#31. This is beneath the standard of care. Patient C.E. should have been referred for endodontic treatment prior to permanent cementation of the bridge.

59. Respondent was negligent in failing to remove all the caries of tooth #31. This caused the tooth to be non-restorable in less than two years. Respondent was negligent in failing to complete the endodontic procedure on tooth #31. Whether Respondent performed this procedure (or if it was present when the old bridge was removed), Respondent was negligent to

permanently cement a bridge with cotton and temporary material sealed inside the tooth. Respondent's actions lead to the loss of tooth #31 and the pontic #30.

FIRST CAUSE FOR DISCIPLINE

(Negligence/Incompetence/Unprofessional Conduct)

60. Respondent has subjected her license to disciplinary action under Code sections 1670, 1680, and 1685 in that she was unprofessional in her conduct, negligent, and incompetent as described in paragraphs 11 through 59, inclusive, as follows:

Patient P.M.

a. There are repeated departures of the standard of care in crown (crown preparation of #20 and #21 is inadequate, with over prepped and convergent walls, with recurrent decay noted on #21) and bridge (bridge preparation of #8-#10 and/or lab work is deficient) and endodontics (poor fill in tooth #21 and a too-short post that is off-center, causing fracture of the tooth and almost perforates the tooth).

b. Early endodontic referral may have prevented the fracture of #21. A final bridge that meets the patient's expectations should have been permanently cemented for #8-#10.

c. There is extremely poor record keeping. There are many entries with no signatures. For endodontic therapy on tooth #21, there is no clinical entry, no note of anesthetic, rubber dam use, medicaments used for irrigation, file working length film, note of working length or temporary or permanent restorative material.

d. The preparation of design of tooth #8-#10 is in question because the porcelain fractured early in its use. The conical and short preparation of tooth #20 was noted by another dentist when the crown had to be recemented.

e. Respondent left the country and allowed her license to go inactive while Patient P.M. was in a temporary bridge.

Patient C.E.

f. Respondent was negligent in failing to remove all the caries of tooth #31, when the tooth was prepped from the bridge in August 2007. This caused the tooth to be non-restorable in less than two years.

g. Respondent was negligent in failing to complete the endodontic procedure on tooth #31. Whether Respondent performed this procedure (or if it was present when the old bridge was removed), Respondent was negligent to permanently cement a bridge with cotton and temporary material sealed inside the tooth. Respondent's actions lead to the loss of tooth #31 and the pontic #30.

SECOND CAUSE FOR DISCIPLINE

(Repeated Acts of Negligence/Incompetence/Unprofessional Conduct)

61. Respondent has subjected her license to disciplinary action under Code sections 1670, 1680, and 1685 in that she was unprofessional in her conduct, negligent, and incompetent as described in paragraphs 11 through 60, inclusive. Respondent practiced in a manner exhibiting repeated departure, at times extreme departure, from the community standard of practice.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct-Record Keeping)

62. Respondent has subjected her license to disciplinary action under Code sections 1670 and 1683 for repeatedly failing to document treatment rendered, as described in paragraphs 11 though 61, inclusive, as detailed above.

PRIOR DISCIPLINE

63. On or about October 17, 2008, in the Matter of the Second Amended Accusation Against Trupti Desai, DDS, Case No. DBC 2007-65, a Stipulated Settlement and Disciplinary Decision Order went into effect wherein Respondent's dental license was publicly remanded and she was ordered, in pertinent part, to enroll in remedial education courses in record keeping and root canal therapy within 45 days of the effective date of the Decision.

64. Respondent entered into a Stipulated Settlement wherein she indicated that she understood and agreed that the charges and allegations in the Second Amended Accusation No. 2007-65, if proven at hearing, constituted grounds for imposing discipline upon her dental license. Respondent further agreed that her dental license was subject to discipline.

65. The First Cause for Discipline in Second Amended Accusation No. 2007-65 (unprofessional conduct- gross negligence and/or repeated negligent acts) arose from

Respondent's actions in cementing a crown on a patient's tooth over an exposed pulp and an unfinished root canal, causing further infection and pain. A subsequent treating dentist discovered the pulp chamber had been exposed (i.e. a root canal had been previously started) and he found a piece of cotton had been left in the tooth. No root canal had been completed. The patient's treatment notes from Respondent's office had no indication that any treatment had been performed on this tooth on the date the patient stated the "root canal" had been performed by Respondent.

66. The Second Cause for Discipline in Second Amended Accusation No. 2007-65 (unprofessional conduct-record keeping) arose from Respondent's repeated failure to document treatment rendered on the patient referenced in paragraph 10, above.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Dental Board of California issue a decision:

1. Revoking or suspending Dentist License Number 47876, issued to Trupti Parthiv Desai;

2. Ordering Trupti Parthiv Desai to pay the Dental Board of California the reasonable costs of the investigation and enforcement of this case, and, if placed on probation, the costs of probation monitoring;

3. Taking such other and further action as deemed necessary and proper.

DATED: 6.14.11

RICHARD DECUIR
Executive Officer
Dental Board of California
Department of Consumer Affairs
State of California
Complainant

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